

# The Medicare SGRrrr Doc 'Fix' and the Transition to VBP

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***Jack Lewin, MD***

***President and CEO***

***Cardiovascular Research Foundation***

***New York, NY, and***

***Chairman***

***National Coalition on Health Care***

***Washington DC***

# A Day of Reckoning Approaches



# Payment Reform Will Change Everything !

- ◆ *FFS rates are flat (= decline) related to the ACA, a new SGR formula, and the economics of rising health costs*
- ◆ *ACOs, shared savings models, PCMHs, bundled payments proliferate*
- ◆ *Capitation will be resuscitated*
- ◆ *It's all going to be about VALUE*

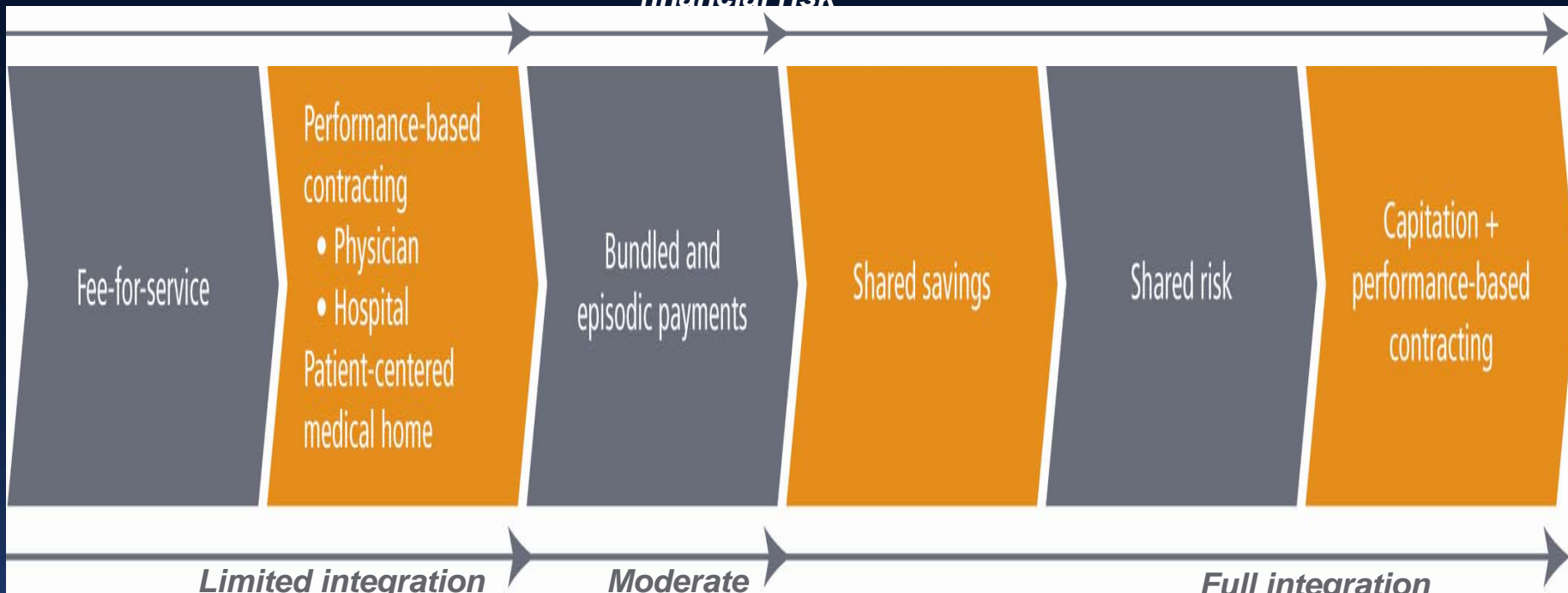
# Journey To Value-Based Provider Reimbursement

## Compensation Continuum (Level of Financial Risk)

Small % of financial risk

Moderate % of financial risk

Large % of financial risk



Encounter Management

Episode Management

Population Management

**Hospitals expect much more of their future reimbursement to be from performance-based risk than do physicians**

**22% of physicians and 40% of hospital executives expect a quarter or more of their reimbursement to be from performance-based risk within 10 years<sup>1</sup>**

# The SGR Fix ! (Medicare Sustainable Growth Rate)

*Will Radically Push Payment  
Reform and Changes in  
Reimbursement*

# The Fix

- ◆ *Senate Finance Committee*
- ◆ *House Energy and Commerce*
- ◆ *House Ways and Means*
- ◆ *All three are now aligned on payment solutions for Medicare*

# The Similarities

- ◆ *No SGR Cut; but a 10 year FFS freeze\**
- ◆ *All give incentives for alternative payment models (APMs) up to +5%*
- ◆ *APMs = PCMHs, ACOs, bundles, or other new models*
- ◆ *After 2023, FFS: +1% yr; APMs: +2% yr*
- ◆ *PQRS + VBM + MU incentives merged*

But all the **real upside** (  $\pm 9\%$  )  
will come from taking risk, not  
staying in FFS !

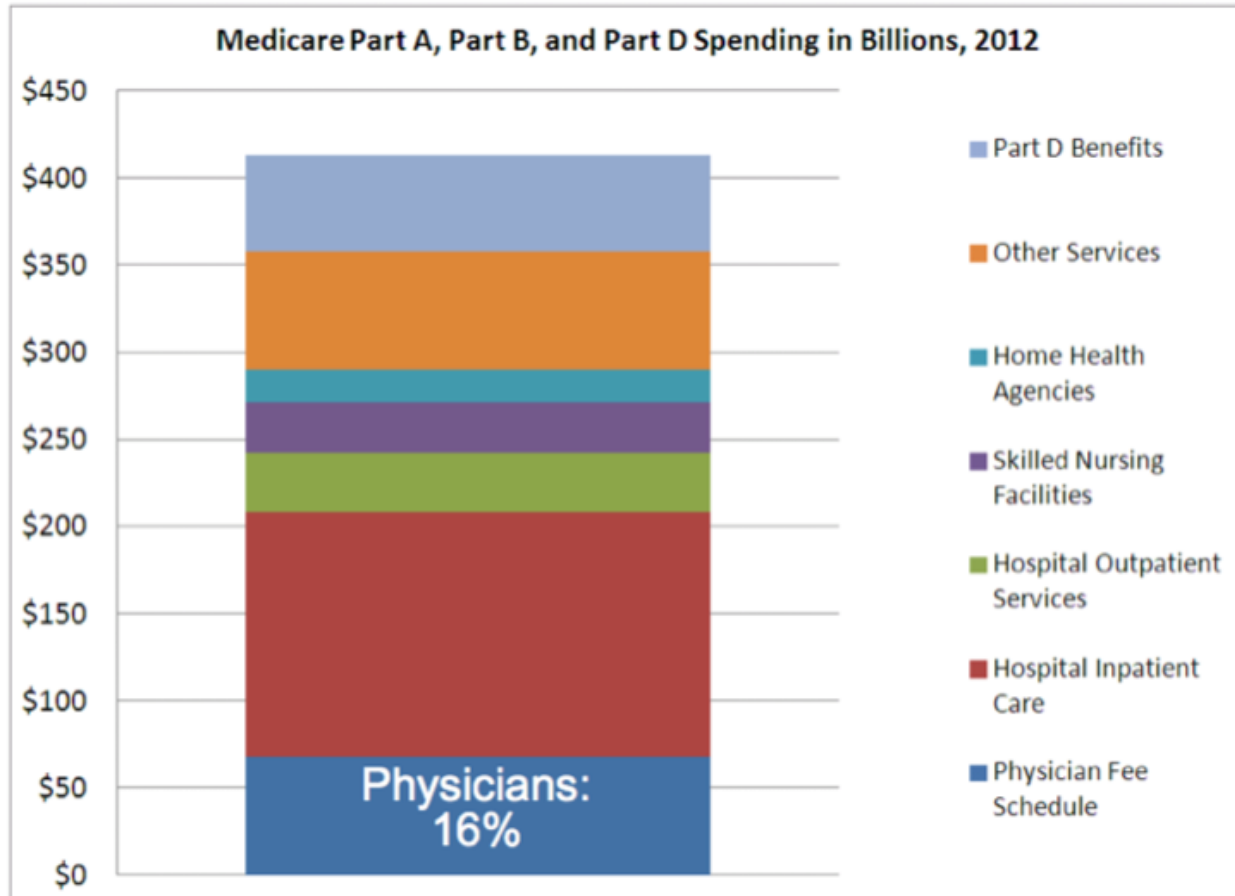


# Impact of SGRrrr on Private Insurance?

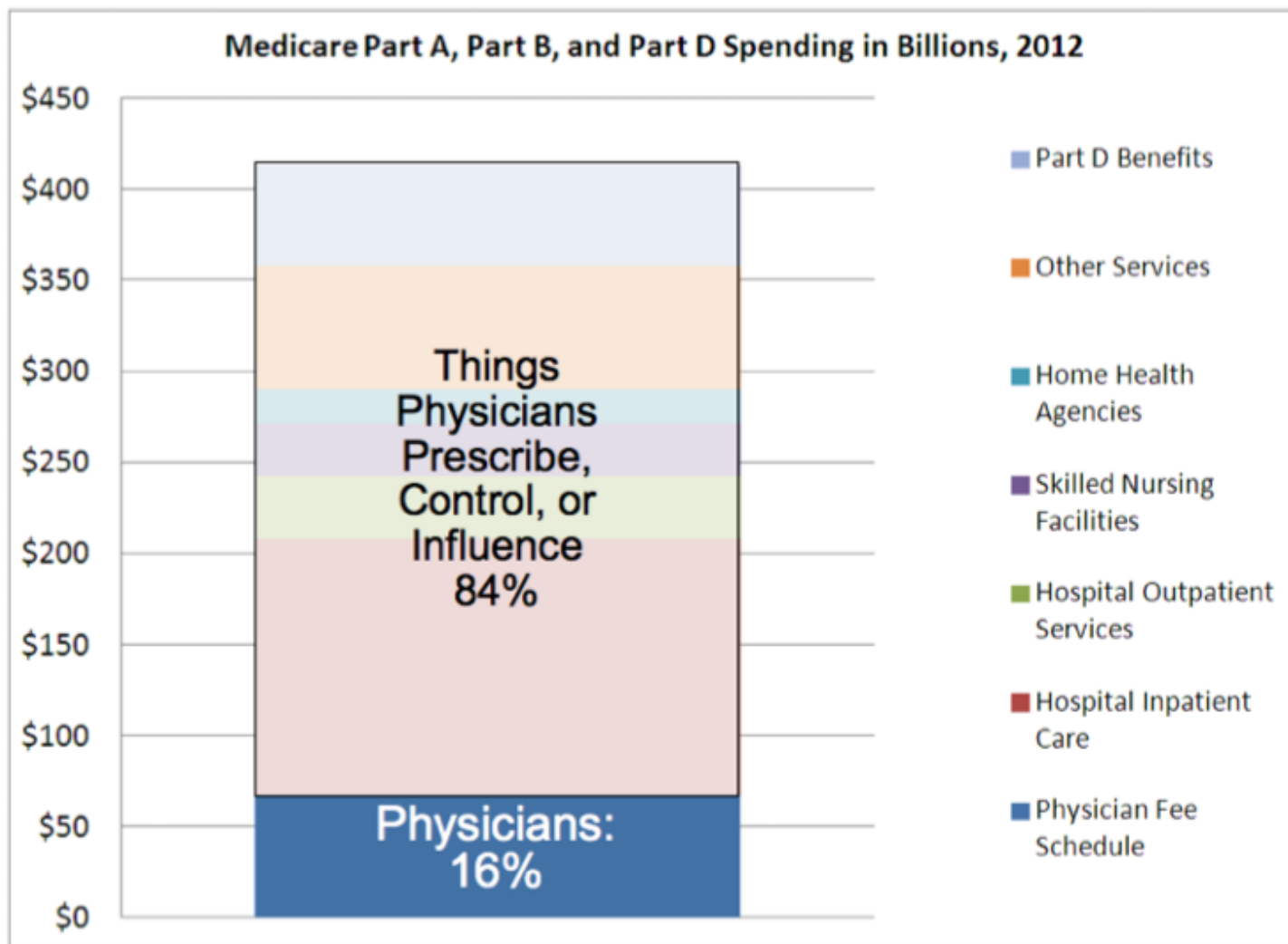
- ◆ *The same strategies on steroids !*
- ◆ *Medicare Advantage*
- ◆ *The Massachusetts BCBS AQC*
- ◆ *The spectre of capitation over time*
- ◆ *What does this mean for employed physicians?*

# Only 16% of Total Medicare Spending Goes to Physicians

And under 5% of Spending in a Medicare Bundle goes to the Primary Accountable Physician



# Most Medicare Spending Goes to Things Physicians Can Influence



# Bundling CV Care to Create an Upside in Quality and Reimbursement

*How gain-sharing can work for interventional cardiology...*

		5%	10%	15%	20%
Cost of Episode (PCI, TAVR, HF, etc.)		\$30,000	\$30,000	\$30,000	\$30,000
Medicare's Discount Guarantee		(\$600)	(\$600)	(\$600)	(\$600)
Target Price (Cost)		\$29,400	\$29,400	\$29,400	\$29,400
Achieved Savings		\$1,470	\$2,940	\$4,410	\$5,880
Overhead Cost Estimate		(\$600)	(\$600)	(\$600)	(\$600)
Gain-share Funds Available		\$870	\$2,340	\$3,810	\$5,280
Dividing Up the Gain-share		\$870	\$2,340	\$3,810	\$5,280
CV Group and Medical Share	50%	\$435	\$1,170	\$1,905	\$2,640

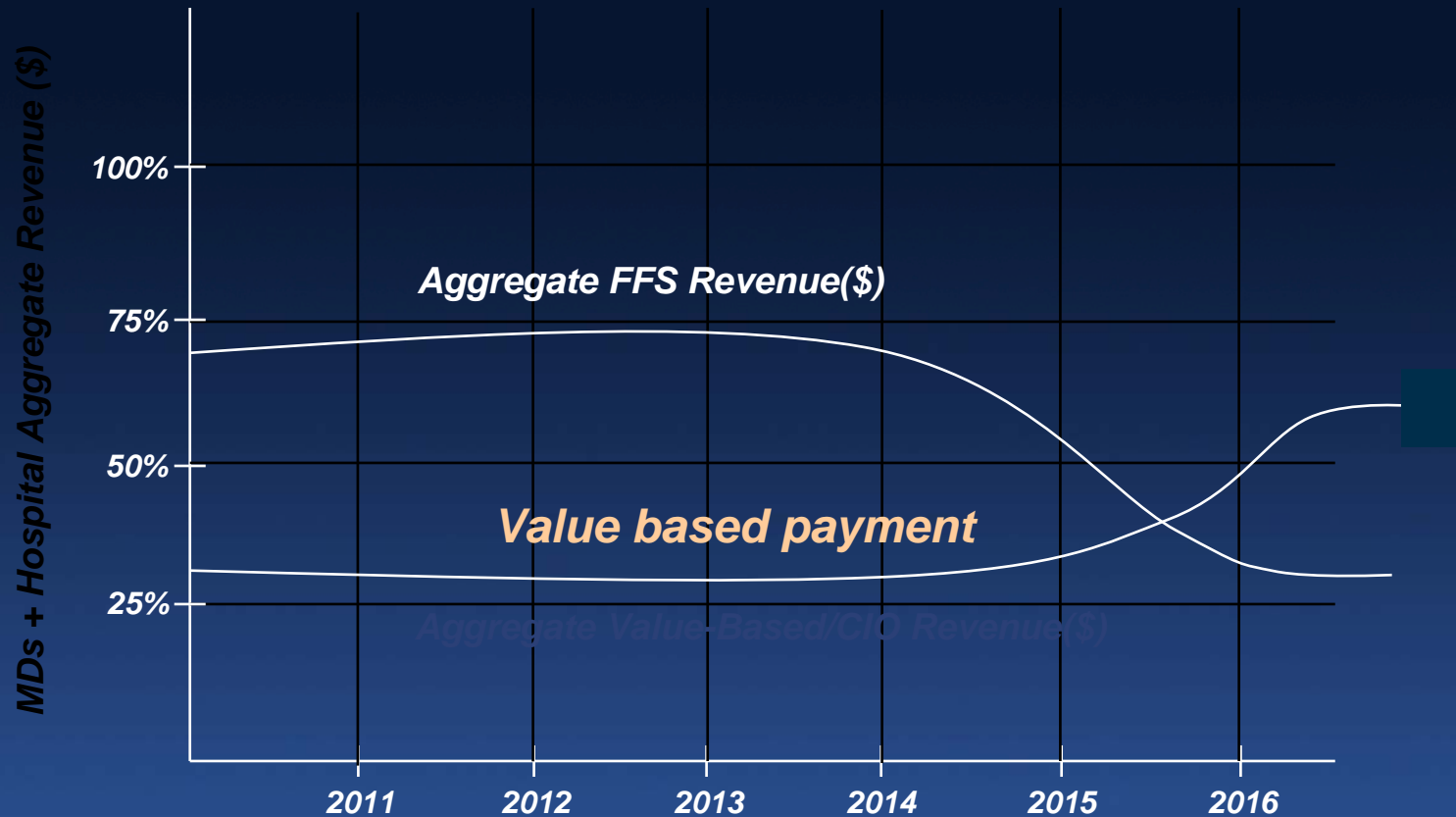
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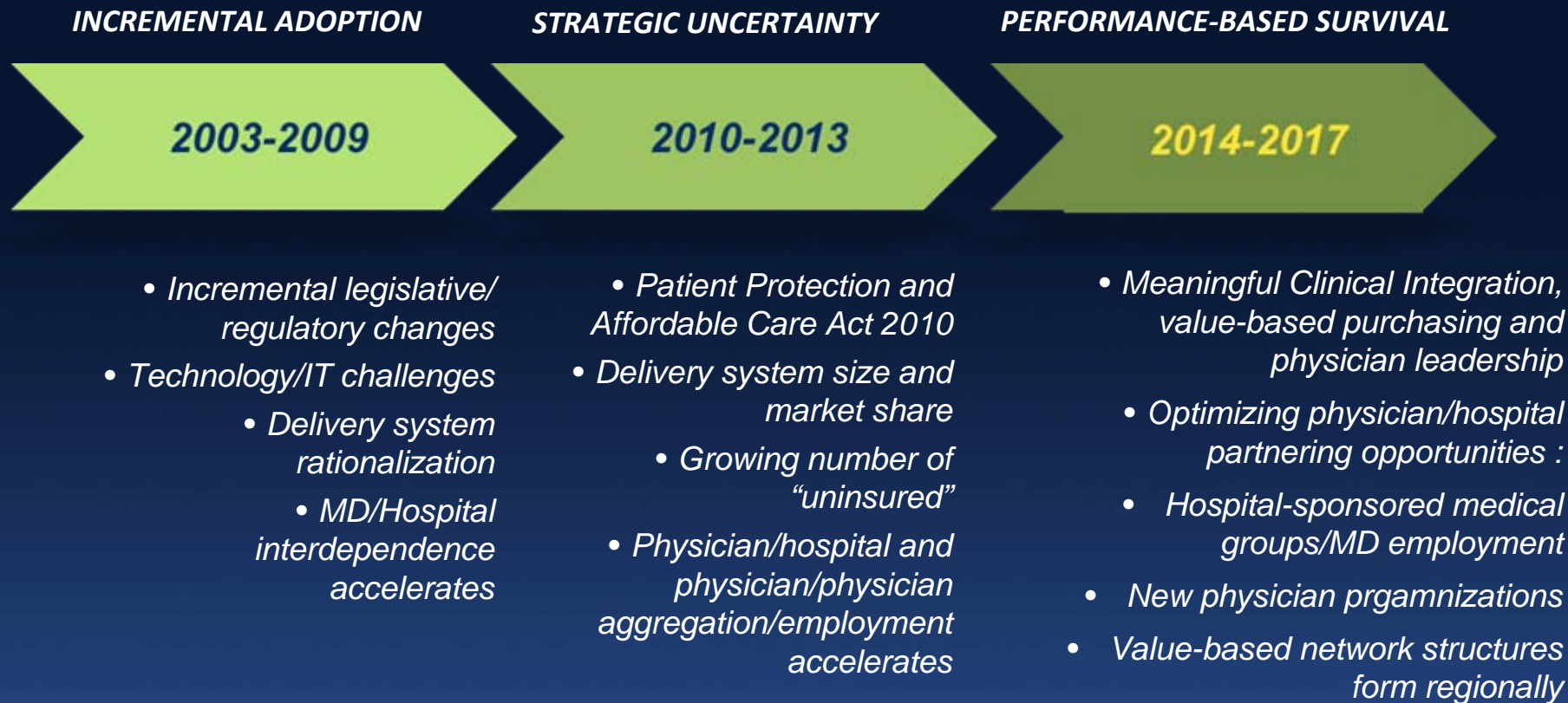
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# Managing Reimbursement Increasingly Complex

Alternative reimbursement methodologies will occur simultaneously and require different types of physician/hospital alignment models



# The Accelerated Push to Performance-Based Survival



# *The Reimbursement Future: Winners and Losers*

- ◆ *“Value-based payment” will apply to doctors, hospitals, drugs, and devices*
- ◆ *Supply & demand still affects payment*
- ◆ *Taking calculated risk will pay off*
- ◆ *FFS is flat (except discretionary care)*
- ◆ *Patients will be key: they will influence more and pay a lot more!*





“The best way to predict the future is to  
**create it.**”

*~Peter Drucker*